

COBRA NOTIFICATION/ELECTION FORM

Date _____

Soc. Sec. Number _____

RE: NOTICE OF RIGHT TO CONTINUE GROUP HEALTH INSURANCE COVERAGE

If you wish to elect coverage through COBRA you **must**:

- complete and return this COBRA Notification/Election Form.
- complete and return insurance applications with the COBRA form. You may obtain the insurance applications from your agency Personnel Assistant. Separate applications are required for health and dental.
- send your check for at least the first month's premium with the above forms. Checks should be made payable to the insurance carrier.

FOR DAS-HRE USE ONLY

dep/ee _____

COBRA exp. date _____

Start direct bill eff _____

INCOMPLETE INFORMATION WILL DELAY THE PROCESSING OF YOUR ELECTION OF COVERAGE

Your State group insurance coverage would normally end as of _____. Federal law, however, permits you to continue coverage, at your expense, for one of the "continuation periods" listed below. NOTE: The term "State group insurance coverage" includes both Medical and Dental insurance coverage. Any person covered at the time of the "event" can elect coverage, including a spouse or dependent, even if the former employee does not elect to continue.

Continuation Period

Coverage may be continued from the date shown above through the earliest of the following:

1. If you qualify for continuation due to termination of your employment or a reduction in your work hours, coverage may be continued for 18 months; 29 months if disabled per the Social Security Administration at any time during the first 60 days of COBRA coverage;
2. If you qualify for continuation for any other reason, coverage may be continued for 36 months;
3. The date you become entitled to Medicare, or you are covered under another group health insurance plan as a result of employment, reemployment, or remarriage, unless there are pre-existing conditions not covered by the plan;
4. The end of the last month for which the premium is paid on a timely basis;
5. The date the State group insurance plan is terminated.

Individual Purchase (Conversion)

When "continued coverage" ends, you may purchase an Individual Health Insurance Policy. Details of the type and levels of benefits to be included in the individual health policy will be made available to you at the time your "continued coverage" ends. Delta Dental of Iowa offers Individual Dental coverage. For information go to www.deltadentalia.com and click on 'Individual Dental,' or call 877-423-3582 and choose Option 3.

Election and Premium Payment

If you decide to continue either the State group health or dental insurance coverage or both, please complete the reverse side of this form and return it within 60 days after the later of: (a) the date coverage would otherwise end, or (b) the date of this notice.

The State group health insurance plan currently in effect for you is _____ single/family. The monthly premium (subject to change) to continue coverage will be \$ _____. Please make your check or money order payable to the health insurance carrier. You currently have single/family dental coverage and the monthly premium (subject to change) to continue coverage will be \$ _____. Please make your check or money order payable to Delta Dental.

The insurance company will bill you directly for subsequent monthly premium payments. Failure to make timely payments will be cause for termination of coverage.

The premium payment must be submitted to the insurance carrier within 45 days of the election in order to continue coverage. Failure to make full payment would be cause for continued coverage to be disallowed. If you wait until close to the end of the 60-day time limit to elect coverage, more than one premium payment may be necessary.

Carefully consider your insurance needs. If you need further assistance contact the personnel assistant in the agency where you work.

You must return this form, check and insurance application (available from the agency's Personnel Assistant) to:

Iowa Department of Administrative Services –
Human Resources Enterprise
Group Health and Dental Benefits
Hoover State Office Building
Des Moines, Iowa 50319

Qualifying Event: _____
(Termination of Employment, Death of Employee, etc.)

Date of Qualifying Event: _____

TO BE COMPLETED BY THE QUALIFIED PERSON

1. Coverage is to be continued: Yes ☐ No ☐
2. If "yes" is checked, please complete the items below. If "no" is checked, please sign, date, and return this form to the above address.
3. Coverage is to be continued for: Health ☐ Dental ☐
☐ Myself only
☐ Myself and the following dependents
Names of dependent(s) _____
4. The subscriber's name to which you are currently a dependent (if applicable):
_____ Social Security # _____
5. Qualified Person: Birth date (month, day, year) _____
Social Security Number _____
Telephone (area and number) _____

(Signature of Qualified Person)

(Date Signed)